STATEMENT OF SENATOR CHARLES GRASSLEY
Senate Special Committee on Aging
April 13, 1999

"Beneficiary Beware: Inadequate Review of Medicare Managed Care Plans Results in Incomplete Information for Consumers"

I am pleased to hold this hearing today, and I want to extend my gratitude to the witnesses who will testify before this committee. This hearing represents a third in a series of hearings this committee has held to examine how Medicare enrollees are educated about the Medicare program. Last Congress, Senator Breaux and I held two hearings, one prior to the passage of the Balanced Budget Act (BBA) of 1997, which resulted in legislation we introduced and subsequently passed to establish the National Medicare Beneficiary Education Campaign. We held another hearing after BBA became law to examine how beneficiaries were navigating this new world of MedicarePlusChoice and how to improve the information we provide them.

Today's hearing results from extensive work the General Accounting Office has done for this committee on this topic. I am pleased to announce that we are releasing two GAO reports at today's hearing. The reports address two important components of the Medicare managed care program. They are: (1) the Health Care Financing Administration's (HCFA) review process for approving managed care plan materials, and (2) the Medicare appeals process.

Both reports are interrelated in a very important way and are the subject of today's hearing. The point of entry for Medicare beneficiaries into the MedicarePlusChoice program is through the marketing process conducted by the plans. We often hear from the plans that their marketing materials are approved by HCFA, but what exactly does that mean. We asked the GAO to take a look at what the review process entails and how it is working. One of the key components of the marketing process is the document beneficiaries receive describing their benefits and rights as an enrollee in a MedicarePlusChoice plan. It may come as a surprise to you as it has to me, that HCFA does not require any standard type of document that contains a full disclosure of benefit coverage. Plans send an array of materials with no one identifying piece of information designated as the beneficiaries' contract of benefits with the plan. The plans must simply provide a summary of benefits and this can vary greatly across plans in format and content. Some plans choose to disclose the benefits in greater detail, but some plans merely provide a brief summary with a disclaimer telling the beneficiaries they must request full disclosure. Many beneficiaries rely on the verbal assurances they receive from marketing representatives that a benefit is covered. Summaries are useful and assistance from plan representatives is essential, but this should not be the only way beneficiaries are told of their benefits.

When information is inadequate or misleading, this leads to confusion and in some instances an appeal by the beneficiary over what is covered or not covered by the plan. To further add to their confusion, enrollees are not given a clear or consistent description of the appeals process, leaving them feeling helpless and alone. Many beneficiaries believe their only alternative is to disenroll from the plan. This is costly and time consuming for everyone involved and as our witnesses will tell us, is not always their preferred choice.

It is often the case that when seniors leave traditional Medicare for a managed care plan, they believe they are no longer in Medicare. Their inability to identify their MedicarePlusChoice plan as being part of Medicare can often lead to confusion and a misunderstanding of what they are entitled to under the program. We will hear from two Medicare enrollees this afternoon who will describe how their difficulties in obtaining the kind of useful and reliable information and assistance they needed reeked havoc on their lives.

We will also hear from a representative from a State Health Insurance Program, which I will refer to as SHIP, who will testify about her experiences assisting Medicare beneficiaries through the maze and confusion of understanding their benefits and their rights to appeal when problems arise. The SHIPs are to many beneficiaries the ombudsmen of Medicare. These programs provide a tremendous amount of support and counseling to Medicare enrollees across the country and train volunteers in local communities to assist with their mission. For the third year in a row, Senator Breaux and I are requesting additional federal funds for this program. We are also seeking recognition of this program by the appropriators through a distinct line item, which the program used to have. Their funding is now part of HCFA's budget and is inadequate to meet the increasing demands for information and assistance by seniors. Our hope is that the program can expand its capacity to help educate and provide counseling to Medicare beneficiaries across the country in both traditional Medicare and MedicarePlusChoice. We encourage our colleagues on this committee and in the Senate to support increased funding and recognition for these statewide programs.

We will also hear from a former HCFA regional director who ran the managed care division in the Atlanta region, during a time of high growth in managed care, about the problems he saw with the review process and program operations. Also, we will hear from HCFA about what they are doing to improve program operations. Finally, the GAO will testify about their findings and recommendations.

Our goal at this hearing is to offer constructive insight and recommendations on ways to improve the HCFA review process and the means by which seniors get information about their benefits and rights under MedicarePlusChoice. I do not want folks to leave this hearing with the impression that we want to restrict plans from marketing to Medicare beneficiaries or from running their business the way they see fit. That is not my objective.

Our focus and attention should be on the beneficiary because that is what this program is about. Medicare is a federal program, and Congress has the responsibility of making sure beneficiaries are receiving the kind of high quality care and assistance they deserve. My primary interest and the interest of this committee is to learn how we can improve the operations of the program and to simplify the information seniors are provided when they enter a managed care plan. Beneficiaries are bombarded with information daily from many different sources, but it is our jobs in Congress and at HCFA to make sure we provide them with the tools they need to understand the program; to know what their benefits are regardless of their choice of how to receive those benefits; and to be able to successfully navigate the appeals process when problems arise.

I hope this hearing will shed some light on these issues. I look forward to hearing from all of our distinguished witnesses here today.